UCI medical affiliates | Doctors Care | Progressive Physical Therapy

Authorization for Release of Health Information

Expires upon one time release of information.

Patient Name: _____ DOB: _____

Address: _____

City, State ZIP: _____ Phone: _____

Email: _____

I authorize UCI Medical Affiliates Inc. and its properties to release my health information to:

☐ Self ☐ Other (specify below):

Name: _____

Company/Organization: _____

Address: _____

City, State ZIP: _____ Phone: _____

Email: _____ FAX: _____

Disclosed health information to include:

☐ Imaging ☐ Provider Notes ☐ Lab Reports

☐ Other: _____

Patient Information

I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. *I understand that information disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.*

I understand that I have the right to revoke this authorization by sending a written notification to UCI Medical Affiliates. I also understand that a revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification.

Written notification may be sent to **legalrecordrequests@ucimedinc.com**

Expiration Date/Event: _____

X _____ _____

Signature of Patient or Personal Representative Date

_____

Description of Personal Representative's Authority (attach documentation as necessary)

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